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A Three-Tiered Approach to Developing a Family-Centered Child Welfare Practice

September 2002

The Massachusetts Department of Social Services

The Massachusetts Department of Social Services has committed itself to fundamentally revising the nature of its child welfare practice. In doing so, the Department is building on a consistent strain of thought, belief and practice that looks to ensure the safety of children in a manner that holds the best hope of nurturing a sustained, resilient network of relationships to support the child's growth and development into adulthood. This strain of practice—deemed "family-centered" for shorthand—has provided the intellectual and emotional energy for a wide array of innovation in the Department in recent years. Its adherents are active at every level of the Department. Active discussion of "family-centered" practice pervades the Department. But it cannot claim to have yet won the full allegiance of the Department, in either theory or practice.

There is a considerable substrate of belief in the Department that dismisses the "family-centered" emphasis as too risky to the child, too unrealistic about the capacities of families, or too embroiled in the emotional life of the child. Some who resist it are steeped in a traditional adversarial "child protective" model of the work. Others arrive at the Department trained in a "case management" model of child welfare work that minimizes the relational dimension. Still others consider it a worthy, but romantic ideal, that is unachievable in public systems that lack the resources or public support they believe are necessary to achieve it. Whatever the ground of scepticism, the "family-centered" approach to child welfare still struggles for the allegiance of the Department.

As a result of this unresolved, long-standing debate about core values and practices, there are profound inconsistencies in the practice of child welfare in Massachusetts. These inconsistencies take the form not only of variations in practice among individual social workers and offices; they also infect the formal structures and processes of the Department. The messages conveyed to staff by the Department's formal structures and processes about the nature and purpose of child welfare practice are often compromised and unresolved. Many in the Department experience authority in the system as highly arbitrary, in large measure as a result of the Department's inconsistency in its expectations of workers and their practice. While different Commissioners and their administrations might be viewed as having veered between the two poles of "child safety" and "family stabilization and reunification," the Department has never attempted a consistent statement of the nature of its child welfare practice. To do so would constitute and require a fundamental revision in the nature of the Department's practice.

The Department is now embarked on a course to define the core practice values that underlie its practice of child welfare, and to align its philosophy and structures in accord with those values. In charting this course, the Department is attempting to bring the logic

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of "family-centered" practice to each aspect of its work. This requires a fundamental rethinking of basic work processes and organization. The process we envision will build on the Department's long-standing and developing tradition of family-centered practice; but in its comprehensiveness and coherence, it will result in innovations in practice that will fundamentally revise the way we do child welfare work, not only in Massachusetts, but potentially across the nation.

Six Core Practice Values

In pursuit of its commitment to a coherent approach to the practice of child welfare, the Department has initiated a conversation about its core practice values. That conversation has begun among the leadership ranks of the Department, but is rapidly expanding to embrace parents and families, front line staff, providers, foster and adoptive parents, and other stakeholders in the protection of children. In the course of these conversations, we intend to develop a statement of the Department's core practice values, their definition, and examples of their application in practice.

To date, we have identified six core practice values. We have not yet agreed on the language to properly capture those six values, but the key domains of belief are clear. In the proxy language that serves to facilitate discussion without crystallizing concepts, the six practice values are:

1) Child-centered;
2) Family-focused;
3) Strength-based;
4) Community-based;
5) Culturally competent/diversity sensitive; and,
6) Committed to continuous learning.

As we refine our language and elaborate the definitions of these core values, we will make clear that they are not about choosing between "safety" and "family stabilization and reunification". They instead delineate an approach to child welfare that is rigorously focused on preserving the physical safety of children, so that we may seek to ensure their emotional safety. These values are founded in the understanding that ensuring the welfare of children cannot be premised on a simplistic or reductionist focused; like parenting, it requires complex, but coherent, goals.

We look to these practice values to anchor our practice. We can constantly assess our practice by testing whether it embodies these core values. And when we are confused or at a loss as to how to proceed, we can return to these core practice values to guide our way out of confusion or impasse. In our commitment to a consistent set of values, we can offer the assurance of a sustained and trustworthy relationship to children, and offer a consistent and coherent engagement with families and caregivers.

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Embodying Practice Values: The Three Tiers of Organizational Change

The Department recognizes that it must do more than simply enunciate its core practice values. To translate its espoused values into values in action, the Department must revise its core work processes and policies to align with these values. This requires a simultaneous focus on an integrated revision of practice at three levels of organization:

1) Clinical Practice: Family-Centered Practice Models
2) Managerial Practice: Departmental Quality Systems
3) Systemic Practice: The Community System of Care

Since these three levels of practice—the clinical work of frontline social workers, the managerial work of Departmental supervisors and leaders, and the systemic work of the Department, family and institutional providers, public agencies, and community organizations—all reflect and embody fundamental practice values, they will operate at cross purposes unless they are consistently aligned. This is the work of organizational change, but it must be more; it must become a movement.

Clinical Practice -- Family-Centered Practice Models

In order for the Department to practice family-centered child welfare work, all staff who work with families, whether public or provider, need to experience families as a partner and resource in the work of protecting and nurturing children. This experience has to be sufficiently frequent and compelling to make the logic of family-centered work transparent to all. It should make the Department and its partners and providers *want* to engage in family-centered practice, because of its evident benefits.

Three Family-Centered Initiatives

At present, there are three Departmental initiatives that are immersing staff in a deeper experience of family-centered practice: Family Group Conferencing (FGC), strength-based service planning, and the Comprehensive Family Focused Care (CFFC) initiative. Casey is thoroughly familiar with FGC, having supported its introduction into the Department. Strength-based service planning was developed by staff of the Lynn Area Office, under the leadership of John Vogel, a supervisor in Lynn. CFFC is a joint initiative of the Departments of Social Services, Mental Health, Medicaid, Youth Services and Education. It will be described in greater detail in a subsequent section on the Community System of Care.

These three initiatives build on a burgeoning history of family-centered innovations in child welfare practice in Massachusetts. These innovations, briefly summarized, include:

- Kinship Focus – Several years ago, the Department adopted a formal policy of relying on kinship care wherever feasible.
- Family-Based Services – Implemented statewide, FBS provides flexible, coordinated contracted services to families in a strengthened collaboration among DSS staff, providers, families, and community supports.

- Community Connections – A neighborhood-based, resident-driven network of coalitions in 22 high-risk neighborhoods to build a comprehensive continuum of family support to address and prevent child abuse and neglect.
- Domestic Violence – Massachusetts was an early innovator in this area, building a partnership with the non-offending parent to create safety for the child within the family context.
- Patch Teams – A demonstration of service delivery that integrates DSS child protective work with the neighborhood prevention work of Community Connections, in one urban and one rural site in Massachusetts.
- Nurturing Programs – The Family Nurturing Center of Massachusetts has worked with the Department to implement a variety of curricula designed to strengthen child/parent relationships in various neighborhoods.
- Family Advocacy – Seven family advocates work in Community Connections sites to ensure that the voices of families are included in service planning and that informal, non-traditional resources are brought to the table in child welfare practice.

Together, and in concert with these earlier initiatives of the Department, FGC, strength-based service planning, and CFFC immerse staff and providers in the experience of a family-focused clinical practice. To date, the three most recent initiatives have been moving forward independently, each on their own timetable, each with its own rationale. We now view them not as independent initiatives, but as the newest components in an integrated family-centered practice, that represents the model of practice that the Department espouses as its core approach to child welfare. We therefore intend to integrate their implementation in sites that have not yet adopted them. We have seen the immensely powerful impact of each of these changes in practice on the philosophy and commitments of those who have participated in them. We are seeking to enlist the synergy of their simultaneous adoption by offices to help fuel the transition to a consistent family-centered practice.

The Three Key Risk Factors and Family-Centered Practice

At the same time, we recognize that this synergy will only develop if we have the tools to support an effective family-centered practice. We are not romantic about family-centered practice; it is not self-executing. Child welfare staff need to know how to support families in their efforts to ensure the safety and well being of their children, and they need the resources and training to help families understand and practice preventative strategies that promote healthy family relationships, communication and discipline.

In order to ensure that family-centered practice is truly effective in ensuring the safety of children, we are concentrating on developing detailed guidance and models of practice to address the three key risk factors for children: family violence, substance abuse and mental illness among caregivers. We are working with Dr. Jack Shonkoff of the Heller School at Brandeis University, whose pioneering work on "*From Neurons to Neighborhoods*" has fostered public recognition of the importance of these three risk

factors. We know that these three risk factors are present among caregivers, singly or together, in the overwhelming majority of our cases. We need to examine, learn and delineate what constitutes effective family-centered practice in these circumstances.

We are seeking to elaborate models of family-centered practice in the presence of these three risk factors in two ways:

1) We are initiating a pilot program with the Heller School and the Department of Public Health to refer all children aged 0-3 who are subjects of a supported child abuse/neglect report to the Early Intervention provider system.

2) We are pursuing a planning grant from the Robert Wood Johnson to bring together all the partners in our community systems of care in a series of conferences and planning sessions, to delineate models of family-centered practice where there is domestic violence, substance abuse and/or mental illness among the caregivers. We intend to focus the discussion of mental illness on depression, the most common and readily treatable form of mental illness among caregivers. Dr. William Beardsley, the preeminent researcher in the field of maternal depression and its treatment, and the Commissioner of Mental Health have both expressed a desire to collaborate with us on this.

Teaming and Family-Centered Practice

Finally, we believe we must reexamine the fundamental work processes of the Department, to align them with a family-centered approach to child welfare practice. We have described to you in an earlier paper our interest in experimenting with alternative practice models, particularly with models of team practice and differentiated practice.

We have described to you how we believe the isolation of frontline workers, particularly those in ongoing units, undermines the quality of practice offered by the Department. In addition, we believe a team approach to practice could afford the opportunity for workers to develop subspecialties, with a particular focus on the three major risk factors described above. We are also interested in experimenting with a more formal differentiation of cases, so that cases are not assigned randomly to workers, but instead are evaluated and assigned in order to accord case content, risk and complexity with the experience and preparation of the worker or team. This might involve the development of higher-ranked high-risk teams, to manage the Department's most dangerous and complex cases.

We have recently hypothesized an additional argument for experimenting with teaming. We have observed that communication, collaboration and learning about case practice are often "sticky" in the Department. Case failure often occurs because information movement within the Department, on both individual cases and broader issues of practice, is often balky or blocked. We suspect that the impermeability of organizational boundaries in the Department is in significant part a result of the initial indoctrination of all workers in a highly autonomous and isolated model of case responsibility and

practice. This indoctrination continues to impede communication and information flow throughout the work life of many of our employees. Teaming in the Department's entry-level position would dramatically alter this culture over time.

As we have previously described, we also are confident that the development of a team model of practice will foster staff commitment to a family-centered and community-based practice. In a family-centered practice model, the child is not treated as an isolated "patient", but instead is understood to be a participant in a collective enterprise that extends not only to extended family members, but to the community and its support institutions as well. A team approach to child welfare practice ensures that the experience of the worker mirrors the collaborative problem solving that family-centered practice relies on.

Family-Centered Practice and the Role of Parents and Families

As we observe the powerful impact of family-centered initiatives on the values and perspectives of those involved in child welfare work, we can envision a virtuous circle developing. In such a dynamic, the positive experience of family-centered practice might lead an Area Office to involve parents and families in increasingly powerful roles in the life of the organization, such as self-assessment, planning or governance. With parents serving as integral partners not only in clinical case practice, but also in the Department's Quality Systems, the push towards a deeper commitment to family-centered practice might increase. In this way, we might observe over time a Department that learns to genuinely live its practice values, in concert with families and communities throughout the state. We would like to explore with Casey Family Programs and the Marguerite Casey Foundation what might best stir such virtuous circles in child welfare practice.

Managerial Practice -- Departmental Quality Systems

In his April letter to the Legislature, the Commissioner outlined an approach to developing a statewide community of practice, using Self-Assessment, Cohort Data, Performance Measures, Professional Development and Program Development to constantly improve practice in a continuous learning model. The critical elements of that vision are moving forward:

1. The Department's IT Division has completed a proof of concept for incorporating cohort data into a tool for presenting and analyzing performance data for self-assessment.
2. The Legislature has endorsed the establishment of a child welfare professional development Institute, and design of the Institute is proceeding in a tripartite process with Salem State's Graduate School of Social Work and the University of Massachusetts Medical School. UMass has offered to provide the working capital for both Title IVE claiming systems and for funding the Institute.
3. We are reorganizing the Program Development arm of the Department by integrating the previously separate residential, family based services,

community connections, foster care and adoption and domestic violence units into a cohesive Planning and Program Development unit, tasked with supporting the Department in its transition to a community-based, family-centered practice.

Today, we would add two additional components to the Departmental Quality Systems: leadership development and critical incident and failure review.

The Department has committed to providing an immediate focus on leadership development to its expanding professional development efforts. Field staff are engaged in discussions of the design of a leadership development program, and the IVE Institute planners have been charged with focusing first on leadership development. Experience in and commitment to family-centered practice will be a key criterion for advancement in the Department.

The Department has also begun to revise its Quality Assurance procedures for comprehensive systems review and for failure review. Out of our first comprehensive review of a single area office, the Whitinsville Area Office, we will develop a formal template for Area Office reviews. At the same time, we are proposing to partner with Shell Oil's state-of-the-art "failure review team" to hone our investigations of incidents of system failure to maximize learning.

The development of a comprehensive Quality System within the Department offers extensive opportunities for the involvement of parents and families in the process of continuous reflection and learning. By involving parents and families as key partners in its Quality System, the Department ensures that its learning is deeply informed by the actual experience of those the child welfare system is directed towards. Families and professionals will define high quality family-centered practice collaboratively, and will engage in constant dialogue to advance it.

We will need the support of Casey Family Programs and the Marguerite Casey Foundation to develop this model of Departmental Quality Systems in an evidence-based approach to organizational improvement.

Systemic Practice -- The Community System of Care

The Department's work is increasingly conducted as a partner in community systems of care. Not only do we rely on our own private provider network for services to our children and families; we frequently depend on services from other independent public and private entities, such as schools, other state agencies, and community organizations. Wraparound models of care, single point of entry systems, and school-based models are examples of the treatment initiatives that enlist us ever more intimately in collaborative practice with others.

In recognition of the need for the Department to organize itself for such integrated collaborative work, we have organized a comprehensive review of our procurement policies, practices and models of care. We have charged a core group of providers, staff and parent representatives with the task of redesigning the structure of our purchased services. This review has already focused on the segregated nature of our managed care services – one for residential care and the other for community-based, family-focused care – and has begun designing an integrated system, with a family and community focus. We will be similarly examining the alignment of incentives in our managed care systems, to ensure that they comport with our core practice values. The role of parents and families in decision-making about care, in ongoing treatment and in the oversight and governance of our managed care and purchased services will be a major topic of review and revision.

While the Department is engaged in a review of its own role in supporting community systems of care, we are partnering with community organizations, parents and families and other public and private providers in an ambitious initiative to establish Comprehensive Family Focused Care systems (CFFC's) in six cities of the Commonwealth. These six sites are envisioned as a prelude to expansion to all of the state's major urban areas. DSS has joined with the Departments of Mental Health, Medicaid Administration, Education and Youth Services to sponsor and fund these integrated community-based, family-focused systems of care for children with severe emotional disturbance and their families.

In the design phase, the Department of Social Services has been a strong proponent of empowering families to make the critical treatment decisions in the CFFC systems of care. As the CFFC's are established in each of their new locations, they also serve as the "vanguard" of family-centered practice in child welfare practice at the local level. The prototype for the CFFC, MHSPY in Cambridge/Somerville, has had just such an impact on child welfare practice in those communities, deepening the understanding of and the commitment to families as the critical resource in treatment.

In order to ensure that a broad array of parents and families are involved in the CFFC's at the local level, the Department has supported discussions between the Federation for Children with Special Needs and local foundations, aimed at engaging parent and family groups in the CFFC cities, as the new systems of care are initiated and undertake their work. Models of parent and family involvement in the oversight and governance of the CFFC can help to foster Departmental experience with families in previously unaccustomed roles. We expect CFFC sites to be particularly fruitful laboratories for developing new models for Departmental interaction and partnership with parents and families.

* * *

By approaching organizational change at three levels – the clinical, the managerial and the systemic – we hope to foster a creative synergy for change among the three. The three levels are, of course, nested: clinical practice operates in the context of managerial practice, which works within systemic practice. Learning can be derived at any of the three levels, and then shared and transformed to serve the needs of other levels.

The Department is immensely excited at the prospect of developing a coherent and integrated family-centered child welfare practice throughout the Commonwealth. We believe that this task will challenge our capacities for collaboration, invention and "scaling up". We can envision clearly many elements of such a scaled up system of practice, and imagine others. Throughout all of our ambitious visions, we discern constant learning about the nature, locus and texture of partnership between child welfare professionals and parents and families for the protection and nurturing of children.

We hope that Casey Family Programs and the Marguerite Casey Foundation will make this journey with us.

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